STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911637	04/14/2016
NAME OF PROVIDER OR SUPPLIER **LAKEHOUSE WEST**	STREET ADDRESS, CITY, STATE, ZIP CODE **3435 FOX RUN ROAD** **SARASOTA, FL 34231**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced Abbreviated Relicensure survey was conducted 4/14/16 at Lakeview West, an Assisted Living Facility in Sarasota, Florida.

No deficiencies were found.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 27, 2016

Administrator
Lakehouse West
3435 Fox Run Road
Sarasota, FL 34231

Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on April 14, 2016 by representatives of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

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